|  |  |
| --- | --- |
| **First Name:** | **Middle Name:** |
| **Last Name:** | **Suffix:** |
| **Social Security Number:** | **Date of Birth (mm/dd/yyyy):** |
| **Exit Destination:** |
| **Temporary Situations** | **Permanent Situations** |
| * Place not meant for habitation
* Emergency Shelter, including hotel or motel paid for with emergency shelter voucher
* Safe Haven
* Moved from one HOPWA funded project to HOPWA TH
* Transitional housing for homeless persons (including homeless youth)
* Hotel or motel paid for without emergency shelter voucher
* Long-term care facility or nursing home
* Residential project or halfway house with no homeless criteria
* Staying or living with family, temporary tenure
* Staying or living with friends, temporary tenure
* Psychiatric hospital or other psychiatric facility
* Substance abuse treatment facility or detox center
* Hospital or other residential non-psychiatric medical facility
* Jail, prison, or juvenile detention facility
* Foster care home or foster care group home
* Long-term care facility or nursing home
 | * Rental by client, with RRH or equivalent subsidy
* Moved from one HOPWA funded project to HOPWA PH
* Permanent Housing (other than RRH) for formerly homeless persons
* Rental by client, with GPD TIP housing subsidy
* Rental by client, with VASH housing subsidy
* Rental by client, with other ongoing housing subsidy
* Owned by client, with other ongoing housing subsidy
* Rental by client, no ongoing housing subsidy
* Owned by client, no ongoing housing subsidy
* Staying or living with family, permanent tenure
* Staying or living with friends, permanent tenure

**Other Situations*** Deceased
* No Exit Interview complted
* Client refused
* Data not collected
* Other (please specify):
 |
| **Disabling Condition:** | * Yes
 | * No
 | * Client doesn’t know
 | * Client refused
 |
| Disability Type | Disability Determination | If *Yes*, to be of long-continued and indefinite duration and substantially impairs ability to live independently? | Documentation of the disability and severity on file? | Currently receiving services/Treament for this disability? | Start Date or End Date |
|  | Yes | No | Client doesn’t Know | Client Refused | Yes | No | Client doesn’t Know | Client Refused | Yes | No | Client doesn’t Know | Client Refused | Yes | No | Client doesn’t Know | Client Refused | (mm/dd/yyyy) |
| Physical |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Developmental |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Chronic Health Condition |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| HIV/AIDS |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Mental Health Problem |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Alcohol Abuse |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Drug Abuse |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Both Alcohol & Drug Abuse |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

|  |
| --- |
| **Permanent Supportive Housing and Rapid Rehousing Projects Only:** |
| **Residential Move in Date (for clients who moved into permanent housing): \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Domestic Violence Victim/Survivor:** | * Yes
 | * No
 | * Client doesn’t know
 | * Client refused
 |
| **If *Yes* to above; When Experience Occurred:** | * Within the past three months
* Three to six months ago (excluding six months exactly)
* Six months to one year ago (excluding one year exactly)
 | * One year ago or more
* Client doesn’t know
* Client refused
 |

|  |  |  |
| --- | --- | --- |
| **If *Yes* to above; Are you currently Fleeing?** | * Yes
 | * No
 |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Currently covered by health insurance?** | * Yes
 | * No
 | * Client doesn’t know
 | * Client refused
 |
| **If *Yes* to above; Insurance Source:** |
| * MEDICAID
* MEDICARE
* State Children’s Health Insurance Program
* Veteran’s Administrations (VA) Medical Services
* Indian Health Services Program
 | * Employer – Provided Health Insurance
* Health Insurance obtained through COBRA
* Private Pay Health Insurance
* State Health Insurance for Adults
* Other (Specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)
 |
| **Currently receiving income from any source?** | * Yes
 | * No
 | * Client doesn’t know
 | * Client refused
 |
| **If *Yes* to above; Income Source and Amount (Monthly):** |
| **Source** | **Monthly Amount from Source** | **Start Date and/or End Date** |
| **Earned Income (employment)** | **$**  |  |
| **Unemployment** | **$** |  |
| **Supplemental Security Income (SSI)** | **$** |  |
| **Social Security Disability Income (SSDI)** | **$** |  |
| **VA Service-Connected Disability Compensation** | **$** |  |
| **VA Non-Service-Connected Disability Pension** | **$** |  |
| **Private Disability Insurance** | **$** |  |
| **Worker’s Compensation** | **$** |  |
| **Temporary Assistance for Needy Families (TANF)** | **$** |  |
| **General Assistance (GA)** | **$** |  |
| **Retirement Income from Social Security** | **$** |  |
| **Pension or retirement income from a former job** | **$** |  |
| **Child Support** | **$** |  |
| **Alimony or other spousal support** | **$** |  |
| **Other Source (please specify):** | **$** |  |
| **Currently receiving any non-cash benefits?** | * Yes
 | * No
 | * Client doesn’t know
 | * Client refused
 |
| **If *Yes* to above; Non-Cash Benefit Source and Amount (Monthly):** |
| **Source** | **Monthly Amount from Source** | **Start Date and/or End Date** |
| **Supplemental Nutrition Assistance Program (SNAP; Bridge Card)** | **$** |  |
| **Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)** | **$** |  |
| **TANF Child Care Services** | **$** |  |
| **TANF transportation services** | **$** |  |
| **Other TANF-funded services** | **$** |  |
| **Section 8, public housing, or other ongoing rental assistance** | **$** |  |
| **Temporary rental assistance** | **$** |  |
| **Other Source (please specify):** | **$** |  |